Coding New Technology: Challenges and Opportunities

ICD-9-CM Coordination and Maintenance Committee
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Dilemma: Irresistible Force Meets Immovable Object

- Irresistible Force of New Technology
  - Rapid Development – Min. Invasive, Bio-tech
  - 5 Year Patient Wait After FDA is Unacceptable
  - Congress Linked Payment to New ICD-9 codes
- Immovable Object of ICD-9-CM Structure
  - Few Codes Left, Several Years Until ICD-10
  - Coding Structure Not Designed for This
  - Need to Maintain Integrity & Consistency of I-9

De-Couple Data from Dollars

- For R-word/P-word, Congress made a new ICD-9 Code **Necessary, but NOT Sufficient**
- Let's collect data for better downstream decisions
- AND for OTHER Uses and Users of ICD-9 Data:
  - Quality/Outcomes Measurement/Monitoring
  - Systems Improvement Studies
  - Effectiveness Evaluations of Systems & Technology
  - Epidemiology, Public Health, Healthy People 2010
  - Evidence-Based Decision Making

Concept Discussion: Three Decision Steps (In Order)

- **1. Process:** SHOULD a Code Set structure with one or more flag code(s) be used to generate more room and faster publication of Guidance?
- (Only answer # 2 and # 3 IF answer to # 1 is YES)
- **2. Location:** WHERE should flag code(s) be:
  - Volume 1-2 (e.g.V-zero) or Volume 3 (e.g.Chapter zero)
- **3. Content:** HOW should Flag codes be WORDED?

Option 1:
We Could Do Nothing More Now

- We could continue to do the best we can with available room and Chapters 0 and 17 until ICD-10 is implemented
- We could hope that manufacturers stop inventing technology (Or at least slow down)
- We could wait until Congress tells us specifically what to do and how to do it

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- OR We can develop our own “New Technology”

“Outside the Box” Solutions: Make Room vs. Find Room

- “Code Sets” consisting of: new “Flag” Code(s)
  - Combined with one or more existing/new codes
  - Together describing the New Technology
- One Procedure code can then represent BOTH:
  - the Old technology (without the flag code) and
  - the New technology(With the flag code)
- E.g. Stent PLUS Flag code=Drug-eluting Stent
  - 36.06 plus Flag code = Drug-eluting Coronary Artery Stent
  - 39.50 plus same Flag code = Drug-eluting non-CA Stent
  - When/if Drug-eluting becomes standard practice, drop flag

BOTH Stable and Responsive

- **Stable:** Systems Updates on Annual Basis – (Meeting Provider and Payor System Needs):
  - Publish for Books and Grouper/Pricer Software
  - Include Flag Codes so they are in Data Edits
  - Any R-word/P-word use on current annual cycle
- **Responsive:** Implement New Technology Through Coding Guidance for Use of Flag Codes – (Meeting Patient and Congressional Needs):
  - Quarterly (Coding Clinic, EAB) or
  - Semi-Annual (post C&M meeting)

Concern: How Easy for Coders to Find Technology Code

- Only Coders in Hospitals Using New Technology Need to Find it to Code it
  - MUST Code New Technology Somewhere
  - Introduction of Technology and need to code is NOT Leisurely – Coding Clinic & EAB regardless
  - Manufacturers will insure clients have guidelines
- Coders in Hospitals Without New Technology
  - Will they care how above hospitals find codes?

IF We Want Flag Codes, WHERE Do We Put Them?

Vol. 1&2 - V-code

- Advantages
  - More Room in codes
  - More Room on bill
- Disadvantages
  - Mix of Dx and Pr
  - External (WHO) Structure Restrictions

Vol. 3 – Chapter Zero

- Advantages
  - All PR codes in Vol. 3
  - Less Structure Constraint
- Disadvantages
  - Less Room in codes
  - Less Room on bill

Content Considerations: How to WORD Flag Codes

- Could be Considered Interim Use
- Trade off:
  - Better Guess at Pipeline ->More Responsive
  - Worse Guess at Pipeline ->"Wasted" Codes
- Single Flag Code
- Numeric Succession (1st Use, 2nd Use, etc.)
- Flag Codes by Body System
- Flag Codes by Approach
- Hybrid